Union Calendar No. 797

93d Congress, 2d Session - - - - - - House Report No. 93-1650

IMPACT OF HEROIN ADDICTION ON THE CRIMINAL JUSTICE SYSTEM

TWENTY-EIGHTH REPORT

BY THE

COMMITTEE ON GOVERNMENT OPERATIONS

DECEMBER 30, 1974.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE

38-906 WASHINGTON : 1974

LETTER OF TRANSMITTAL

HOUSE OF REPRESENTATIVES,
Washington, D.C., December 30, 1974.

Hon. W. PAT JENNINGS,
Clerk of the House of Representatives,
Washington, D.C.

DEAR MR. JENNINGS: By direction of the Committee on Government Operations, I submit herewith the committee's twenty-eighth report to the 93d Congress. The committee's report is based on a study made by its Special Studies Subcommittee.

CHET HOLIFIELD, *Chairman.*

CONTENTS

Union Calendar No.

93D CONGRESS, 2d Session } HOUSE OF REPRESENTATIVES { REPORT No. 93-1650

IMPACT OF HEROIN ADDICTION ON THE CRIMINAL JUSTICE SYSTEM

DECEMBER 30, 1974.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. HOLIFIELD, from the Committee on Government Operations, submitted the following

TWENTY-EIGHTH REPORT

BASED ON A STUDY BY THE SPECIAL STUDIES SUBCOMMITTEE

On December 12, 1974, the Committee on Government Operations approved and adopted a report entitled "Impact of Heroin Addiction on the Criminal Justice System." The chairman was directed to transmit a copy to the Speaker of the House.

INTRODUCTION

The American public has long associated the phrase "drug problem" or "drug abuse" in an ultimate sense with heroin addiction. The widespread concern during the late 1960's about marihuana and LSD stemmed in large part from a fear that the use of these drugs would lead inevitably to the use of and addiction to heroin. Also, for the past six decades heroin has been the main target of Federal and State law enforcement efforts to control the use of drugs. The Federal Government alone spends about $750 million annually on drug abuse, the bulk of which is channeled into efforts to control heroin traffic or treat those addicted to it.[1]

The significance of heroin to the American public is not in the numbers of persons who have become addicted to it. There are an estimated 250,000 to 500,000 heroin addicts in the United States,[2]

[1] "Evaluating the Federal Effort To Control Drug Abuse" (pt. 2), hearings before a subcommittee of the Committee on Government Operations, House of Representatives (Washington, D.C.: U.S. Government Printing Office, 1973), p. 285; hereinafter cited as "hearings."

[2] Hearings, pt. 1, p. 8; "New Perspectives on Urban Crime," a report by the American Bar Association Special Committee on Crime Prevention and Control (Washington, D.C., 1972), p. 29, hereinafter cited as "New Perspectives on Urban Crime."

compared to some 10 million alcoholics and 10 million men and women who regularly take barbiturates or amphetamines without medical supervision.[3] Moreover, about three times as many persons are arrested each year for the possession of marihuana as are arrested for possessing heroin.[4]

Heroin's importance can best be explained by the fear of its strong addictive power and by its close association with crime. The power of heroin to enslave the user is legendary. A large percentage of those who try heroin become addicted and once addicted, find it nearly impossible to "kick the habit." Until recently there was a rule of thumb in heroin treatment programs that about 9 out of 10 addicts "rehabilitated" in prison or through treatment eventually would relapse, even though the actual physical craving for heroin seemingly had been eliminated.[5]

The public's fear of a drug with such overwhelming addictive powers is graphically expressed by the Supreme Court of the United States in a 1962 case involving heroin:

> To be a confirmed drug addict is to be one of the walking dead. * * * The teeth have rotted out, the appetite is lost, and the stomach and intestines don't function properly. The gall bladder becomes inflamed; eyes and skin turn a bilious yellow; in some cases membranes of the nose turn a flaming red; the partition separating the nostrils is eaten away—breathing is difficult. Oxygen in the blood decreases; bronchitis and tuberculosis develop. Good traits of character disappear and bad ones emerge. Sex organs become affected. Veins collapse and livid purplish scars remain. Boils and abscesses plague the skin; gnawing pain racks the body. Nerves snap; vicious twitching develops. Imaginary and fantastic fears blight the mind and sometimes complete insanity results. Often times, too, death comes—much too early in life. * * * Such is the torment of being a drug addict; such is the plague of being one of the walking dead.[6]

Because heroin must be purchased through the black market at exorbitant prices, nearly all addicts support their habit by stealing property and converting it to cash or by selling drugs. The amount of property stolen by narcotic addicts each year is estimated to have a value in the neighborhood of $3 billion.[7] In addition, some estimates attribute as much as 50 percent of the holdups, burglaries, and muggings committed in our major cities to heroin users seeking funds to pay for drugs.[8]

[3] "Drug Use in America: Problem in Perspective," Second Report of the National Commission on Marihuana (U.S. Government Printing Office, Washington, D.C., 1973), pp. 42–58.

[4] Weldon T. Johnson and Robert Bogomolny, "Selective Justice: Drug Law Enforcement in Six American Cities," in Drug Use in America: appendix, vol. III, U.S. Government Printing Office, Washington, D.C., 1972, p. 502, hereinafter cited as "Selective Justice."

[5] Edward M. Brecher, "Licit and Illicit Drugs," Consumers Union, Mt. Vernon, N.Y., p. 78, hereinafter cited as "Licit and Illicit Drugs."

[6] *Robinson* v. *California*, 370 U.S. 660 (1962).

[7] New Perspectives on Urban Crime, p. 31.

[8] Ibid., p. 25.

The criminal justice system is the governmental institution most greatly affected by and with the greatest influence on heroin addiction. Although there are no exact figures on what percentage of our Nation's prison population have been heroin users, we do know that the number is substantial. For example, in New York City and Washington, D.C., authorities claim that as many as 40 percent to 50 percent of the arrestees in jail were heroin users when arrested.[9] In the Federal prison system, the figure has been set at about 30 percent.[10]

Because of this close association between heroin and crime, the American public in general and the criminal justice system in particular have dealt with heroin addition essentially as a law enforcement problem. In 1914, Congress made the possession of heroin a criminal offense punishable by imprisonment up to life.[11] Furthermore, until the early 1960's, when it became more and more apparent that neither the threat of long prison sentences nor imprisonment itself seemed to deter addicts from using heroin or from returning to it after serving time behind bars, most courts took a "lock 'em up and throw away the key" approach to narcotic law violations. In recent years a large number of courts—citing the ineffectiveness of severe penal sanctions, overcrowded prisons, and clogged court dockets, have taken an opposite but equally ineffective approach towards narcotic law violators. In these jurisdictions, the vast majority of individuals arrested on narcotic charges are released back to the streets without imprisonment or medical and psychological treatment. Only a small handful are ever brought to trial, and an even smaller number convicted and incarcerated.

Although from a short-term "economy" standpoint, leniency in dealing with heroin law violators may help reduce some of the expense in prosecuting and imprisoning addicts, this approach has probably created more problems than it has solved. The criminal justice system has in large part become a revolving door for criminal addicts. They are arrested and released back to the streets where, because there has been no interruption of their drug use or criminal behavior, they are soon rearrested on drug charges or for property crimes—beginning the cycle all over again. This revolving door phenomenon adds up to greatly increased costs in enforcing narcotic laws over the long run.

Dealing with heroin strictly as a law enforcement problem is expensive, irrespective of whether the criminal justice system takes a hard-nosed or a soft approach. For example, the District of Columbia alone spends an estimated $7 million for police, $800,000 for court costs, and $9,400,000 for corrections institutions—a total of $17 million annually, just to deal with drug-related crime.[12]

These high costs, coupled with a recognition that the traditional methods or arrest, prosecution, and imprisonment have proved ineffective in breaking the drug use-criminal activity cycle, have caused a growing number of authorities to reexamine the goals and methods of dealing with heroin addiction principally as a law enforcement problem

[9] Ibid., p. 32.

[10] Hearings, pt. 3, p. 735.

[11] 26 U.S.C. 4701 et seq. (now repealed).

[12] New Perspectives on Urban Crime, p. 32.

lem. The traditional goal of drug law enforcement has been to reduce the available supply of heroin, and to keep addicts off the street. However, more and more courts and law enforcement agencies are beginning to recognize the importance of also reducing the demand for drugs through actively participating in the overall process of rehabilitating heroin addicts. As a result, the criminal justice system is being used as a vehicle for channeling addicts into treatment.

The criminal justice system usually is the first and often the only government institution to come into contact with heroin addicts. Thus, if they do not receive treatment at that point of contact, chances are they never will.

BACKGROUND

This report discusses the criminal justice system as it affects and is affected by narcotic users. Its primary concern is with reducing the soaring costs of administering this system through more efficient methods of dealing with heroin addicts who are arrested.

The first sections of the discussion, infra, analyze the arrests and case disposition of drug law violators and heroin addicts arrested on nondrug charges. Later sections examine the costs and benefits to the criminal justice system of diverting addicts into treatment programs, either in lieu of or as part of their sentence.

The report is an outgrowth of the Special Studies Subcommittee's overall investigation of the Federal drug abuse programs.[13] During 21 days of hearings in Washington, D.C., and New York City, in 1973, the subcommittee heard specific testimony relating to the criminal justice system's handling of heroin addiction from Federal prison officials, law enforcement personnel, the judge who administers the Detroit court referral program, and a number of treatment program administrators. Also, subcommittee members and staff met with personnel and inmates at MacNeil Island and Petersburg Federal Prisons, the State correctional facility at Corona, Calif., the District of Columbia Superior Court referral program, the U.S. Department of Justice diversion program, and also visited treatment programs in Washington, D.C., New York City, Seattle, San Francisco, and Los Angeles.

The investigation and hearings mentioned above were the bases of two earlier committee reports: "Evaluating the Federal Effort To Control Drug Abuse: Improving the Federal Strategy," and "Occupational Alcoholism Programs for Federal Employees."[14]

[13] Hearings (pts. 1–4).

[14] "Evaluating the Federal Effort To Control Drug Abuse: Improving the Federal Strategy," H. Rept. 93–602, Oct. 19, 1973, and "Occupational Alcoholism Programs for Federal Employees," H. Rept. 93–1316, Aug. 22, 1974.

FINDINGS AND CONCLUSIONS

1. Heroin addicts account for a disproportionately large number of felony arrests. These include narcotic law violations and various property crimes committed to obtain funds for the purchase of heroin. Most addict-arrestees have been arrested and in some cases imprisoned in the past. Unless they receive treatment for their addiction, the chances are great that they will be rearrested again in the future.

2. Heroin-related crime costs the public billions of dollars in stolen property and added law enforcement, court, and correctional costs each year.

3. In many jurisdictions, the criminal justice system is doing little to break the drug use-criminal behavior cycle that entraps most heroin addicts:

(*a*) Because of crowded court calendars, several months may elapse between an addict's arrest and trial. During the intervening period, most jurisdictions release addicts on unconditional bond back to their communities to resume taking or selling heroin, and committing more crimes.

(*b*) Few addicts arrested on narcotic law violations spend time behind bars and few ever receive treatment for their heroin problem. The vast majority are arrested, released, and rearrested without the bane of punishment or the benefit of rehabilitative treatment.

(*c*) As many as one-third of the inmates in Federal and State prisons have used heroin. Most never receive treatment in prison, and upon release they return to their previous lifestyles of taking heroin and committing crimes.

4. A small but growing number of jurisdictions are recognizing that neither the hard-nosed approach of the past nor the present judicial leniency toward heroin addicts provides them with the treatment necessary to cure their illness or reconstruct their lives. These jurisdictions use the criminal justice system as a point of entry for diverting criminal addicts into treatment. Diversion comes either after arrest and before trial, or after trial and in lieu of or as part of the sentence.

5. Programs that divert the addict into treatment have shown favorable results through reducing relapse to addiction and subsequent arrests. Those who complete treatment show the best results, but individuals who have undergone only a limited period of treatment are less likely to have subsequent arrests than arrestees who receive no treatment at all.

6. Diversion before trial puts the addict in immediate contact with treatment resources. For this system to work effectively, however, it is necessary for the courts and the police to monitor the arrestee's progress in treatment. In the past the pretrial diversion program administered by the District of Columbia failed to do this. As a

result, large numbers of diverted arrestees dropped out of treatment without recrimination from the courts. Posttrial diversion has the advantage of commanding stricter adherence, because failure to complete treatment can result in commitment to prison. The serious disadvantages of posttrial diversion are that it needlessly postpones treatment until the addict-arrestee is actually convicted of a crime, and it does not save the criminal justice system the expense of prosecuting an arrestee.

7. Many addicts will be arrested and convicted of nondrug crimes. The treatment program established by the Bureau of Prisons is an important first step by the Federal Government to rehabilitate rather than simply punish addicted offenders. This approach holds considerable promise for reducing the number of rearrests of Federal inmates.

8. All diversion programs use variants of one of two treatment modalities: Drug-free therapy or methadone maintenance. Methadone is also used for short periods, up to 3 weeks, to detoxify addicts. Substantially more addicts chose methadone programs than therapeutic communities, and the retention rates in methadone programs are consistently higher. Both forms of treatment have been successful in reducing heroin relapse and rearrest:

(*a*) Because participation in a drug-free therapy almost always requires much more intense psychological counseling, court personnel should be careful in prescribing drug-free therapy only to those individuals who they feel can adapt to a rigorous routine.

(*b*) While methadone has proved successful in treating heroin addicts, some methadone programs have simply dispensed methadone, depriving the client of vitally needed counseling and vocational assistance.

9. The treatment of heroin addiction is expensive. However, if it leads to a sizable reduction in relapse and rearrest, it is cost-effective.

RECOMMENDATIONS

1. The Special Action Office for Drug Abuse Prevention, as a condition of approval of State drug abuse plans, should require that States propose treatment programs for inmates in State penal institutions who have a history of drug use. The criminal justice system provides governments with a way of identifying heroin addicts, and incarceration provides an opportunity to treat them. A portion of State heroin treatment resources should be directed to prisons as a potential treatment community.

2. The Special Action Office for Drug Abuse Prevention should encourage States applying for Federal drug abuse funds to develop diversion programs within local jurisdictions to divert arrested heroin users from the normal channels of the criminal justice system into heroin treatment.

3. The Special Action Office for Drug Abuse Prevention should disseminate to State and local judicial districts all information obtained through the Federal Treatment Alternatives to Street Crime (TASC) programs as rapidly as possible to help them in establishing their diversion programs.

4. As a crucial element in helping the criminal addict re-enter the mainstream, of society, Federal and State governments should work with public and private employers to help them overcome the double prejudice against former criminal addicts. As part of the treatment in prison, training in usable occupational skills should be emphasized.

DISCUSSION

Drug Law Violations

Before discussing the diversion of heroin addicts to treatment, it would be well to obtain a clear picture of the numbers of addicts who become involved with the criminal justice system. This section considers the number of persons arrested each year for narcotic law violations at both State and Federal levels. In addition, it presents a hypothetical composite picture of the "normal" course of an average addict-arrestee, from his initial arrest through posttrial disposition.

The number of narcotic and nonnarcotic drug arrests has grown steadily in recent years. Statistics published by the Federal Drug Enforcement Administration show that Federal and State law enforcement agencies arrested twice as many individuals on narcotic charges in 1972 as in 1968.

TABLE 1.—STATE-LEVEL DRUG ARRESTS [1]

	Calendar year—				
	1968	1969	1970	1971	1972
Total arrests	162,177	232,690	346,412	400,606	431,608
Heroin and cocaine	42,328	67,945	107,427	114,573	92,364
Marihuana	78,169	95,868	157,271	183,878	239,111
Synthetic narcotics	8,920	15,125	19,053	26,040	38,413
Other	32,760	53,752	61,661	76,115	61,720

[1] Drug Enforcement Administration: Drug Enforcement Statistical Report, Washington, D.C., 1973, p. 21.

TABLE 2.—FEDERAL DRUG ARRESTS [1]

	Fiscal year—				
	1969	1970	1971	1972	1973
Total arrests	2,265	1,660	2,212	4,579	5,592
Heroin				1,799	2.313
Cocaine	[2] 987	[2] 1,008	[2] 1,284	870	1.443
Other narcotics				77	40
Marihuana	620	143	374	877	980
Hallucinogens	435	293	309	421	350
Depressants	48	52	25	81	84
Stimulants	164	145	167	360	282
Other	11	19	53	94	100

[1] Drug Enforcement Statistical Report, ibid., p. 5.
[2] Reported as narcotics.

A significant number of drug users enter the criminal justice system as a result of nondrug crimes committed in an effort to raise money to purchase heroin. There is no way of knowing precisely how large this group is, since only a handful of jurisdictions perform urinalysis or other tests to determine if an arrestee is using heroin or other drugs at

the time of arrest. However, on the basis of data from these few cities as compiled by the Bureau of Narcotics and Dangerous Drugs (BNDD),[15] we do know that the number is substantial. For example, in a major report entitled "Drug Usage and Arrest Charges," in which BNDD studied the drug use patterns and crime histories of 1,800 arrestees in six major cities, findings were that "if one adopts the broadest definition of drug usage in terms of number of arrestees for whom there was some evidence of their using any drug at any time in the past, then approximately 68 percent of all sample arrestees fell into the 'drug user' classification."[16] The report goes on to state that heroin use among arrestees ranged from a high of 59 percent in New York to a low of 20 percent in St. Louis.[17] In the District of Columbia, which has developed a rather thorough urinalysis procedure, 42.9 percent of all adult arrestees tested positive for heroin in May of 1970, and during a sample period spanning 18 months, 33.6 percent of adults tested at arraignment showed heroin traces in their urine.[18]

The arrest figures compiled by BNDD in the above report have been broken down further to show the relationship between heroin use and specific crimes for which arrestees were charged. These results follow:

TABLE 3.—HEROIN USERS ACROSS ALL SITES, AS DETERMINED BY URINE SAMPLE ANALYSIS, AND ASSOCIATED ARREST CHARGES[1]

UCR crime classification	Drug usage classification: Heroin users		Other urine analysis		Sample not analyzed		No sample obtained		Quinine only	
	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
1. Criminal homicide	1.6	4	3.4	47	1.1	1	1.9	2	2.9	2
2. Forcible rape	.4	1	2.3	31	1.1	1	3.8	4	1.5	1
3. Robbery	18.7	48	14.2	194	12.2	11	14.4	15	27.9	19
4. Aggravated assault	3.1	8	12.0	165	11.1	10	11.5	12	4.4	3
5. Burglary	28.1	72	14.8	203	22.2	20	17.4	18	11.8	8
6. Larceny, theft	17.2	44	12.7	174	17.9	16	13.5	14	14.7	10
7. Auto theft	2.0	5	5.3	73	7.8	7	3.8	4		
8. Other assaults	1.6	4	5.0	68	3.3	3	4.8	5	4.4	3
9. Arson			.7	10	1.1	1				
10. Forgery and counterfeiting	2.0	5	2.0	28	1.1	1	2.9	3	2.9	2
11. Fraud	1.2	3	1.1	15	1.1	1	2.9	3	1.5	1
12. Embezzlement										
13. Stolen property	2.7	7	1.8	24	2.2	2	1.0	1	4.4	3
14. Vandalism			1.2	17			2.9	3		
15. Weapons	7.0	18	5.1	70	11.2	10	4.8	5	2.9	2
16. Commercialized vice			.1	2			1.9	2		
17. Sex offenses	.8	2	2.3	31	1.1	1	1.0	1	1.5	1
18. Narcotic drug laws[2]	10.1	26	8.9	122	1.1	1	7.7	8	14.7	10
26. All other offenses	3.5	9	7.1	97	4.4	4	3.8	4	4.4	3
Total	100.0	256	100.0	1,371	100.0	90	100.0	104	100.0	68

[1] Drug Usage and Arrest Charges, note 16 supra, p. 124.
[2] Note that drug crimes constitute only 10 percent of arrests in this sample of heroin users.

[15] Now the DEA (Drug Enforcement Administration).
[16] "Drug Usage and Arrest Charges: A Study of Drug Usage and Arrest Charges in Six Metropolitan Areas of the United States" (U.S. Government Printing Office, Washington, D.C., 1971), p. 104; hereinafter cited as "Drug Usage and Arrest Charges."
[17] Ibid., pp. 145–187.
[18] Linda Moody, Diana Rae, and Lawrence Cogan, "The Role of Police in the Diversion of Drug Offenders," in Drug Use in America: Appendix, vol. III, pp. 88–90. Later figures show that the percentage of arrestees in the District of Columbia tested positive for heroin dropped to about 10 percent in 1973 during a period of heroin shortage in the District, but subsequently increased and was approximately 30 percent by mid-1974.

TABLE 4.—HEROIN USAGE AND CRIME CLASSIFICATION BY ARREST CHARGE (ROBBERY INCLUDED AS SERIOUS CRIME AGAINST THE PERSON) ACROSS ALL 6 SITES[1]

Drug usage (urine analysis only)	Crime classification: Serious crimes against the person		Less serious crimes against the person		Property crimes		All other crimes		Total	
	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Heroin users	24.6	63	2.3	6	55.5	142	17.6	45	100	256
Other urine analysis	32.2	442	8.8	121	41.3	565	17.7	243	100	1,371
Sample not analyzed	25.6	23	5.5	5	54.5	49	14.4	13	100	90
No sample obtained	31.7	33	5.8	6	47.0	49	15.4	16	100	104
Quinine only	38.2	26	5.9	4	36.8	25	19.1	13	100	68

[1] Drug Usage and Arrest Charges, note 16 supra, p. 125.

Note: Total $X^2=33.68$, 12 df**. Heroin users versus other urine analysis $X^2=25.75$, 3 df**. Quinine users versus other urine analysis $X^2=1.75$, 3 df.

TABLE 5.—HEROIN USAGE AND CRIME CLASSIFICATION BY ARREST CHARGE (ROBBERY INCLUDED AS A PROPERTY CRIME) ACROSS ALL 6 SITES[1]

Drug usage (urine analysis only)	Crime classification: Serious crimes against the person		Less serious crimes against the person		Property crimes		All other crimes		Total	
	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Heroin users	5.9	15	2.3	6	74.2	190	17.6	45	100	256
Other urine analysis	18.1	248	8.8	121	55.4	759	17.7	243	100	1,371
Sample not analyzed	13.3	12	5.6	5	66.7	60	14.4	13	100	90
No sample obtained	17.3	18	5.8	6	61.5	64	15.4	16	100	104
Quinine only	10.3	7	5.9	4	64.7	44	19.1	13	100	68

[1] Drug Usage and Arrest Charges, note 16 supra, p. 125.

Note: Total $X^2=50.96$, 12 df**. Heroin users versus other urine analysis $X^2=44.73$, 3 df*. Quinine users versus other urine anlaysis $X^2=3.95$, 3 df.

Based on statistics from the BNDD study and the District of Columbia court system, the following observations regarding the arrest of narcotic addicts can be made:

(1) There is a growing number of arrests for drug law and narcotic law violations;

(2) A growing percentage of individuals arrested for nondrug crimes are addicted to heroin; and

(3) Arrest rates for all types of crime are higher for narcotic users than for nonusers.

The increase in arrests for narcotic law violations suggests that Federal and State laws are being more vigorously enforced.[19] Testimony received by the subcommittee shows that Federal law enforcement is concentrating on all levels of distribution.[20] In fact, arrest statistics indicate that a majority of trafficking arrests involve traffickers who sell drugs to sustain their own habit rather than those who sell for profit, and involve the possession of small quantities of drugs.[21]

[19] During 1973, the number of drug offense arrests continued to increase. The FBI reports 484,242 drug offense arrests for 1973, compared to 431,609 for 1972, an increase of 52,633. See, "Crime in the United States, Uniform Crime Reports for the United States, 1973," Federal Bureau of Investigation, U.S. Government Printing Office, Washington, D.C., 1973, and table 1 supra.
[20] Hearings (pt. 2), pp. 292–293.
[21] Licit and Illicit Drugs, pp. 97–98.

Regarding the growing number of narcotic addicts arrested for nondrug crimes, some of these undoubtedly would be committing crimes whether or not they were using heroin. Nevertheless, the criminal justice system and the public in general carries a heavy financial burden because addicts find themselves compelled by the economics of the black market to steal large quantities of property to purchase small amounts of heroin.

Most nondrug crimes committed by addicts are property crimes rather than crimes against persons.[22] In fact, the BNDD study determined that heroin users commit fewer crimes against persons but a proportionately larger number of property crimes than do arrestees not using heroin.[23] This finding seems to substantiate the contention made by many treatment experts that heroin per se has little or no effect on the criminal behavior of addicts, and that addicts commit crimes almost exclusively for the purpose of generating income to sustain their habit. One caveat should be noted: Although the incidence of crimes against persons is relatively low for the entire addict population, there has been an alarming increase during the past 5 years in the number of violent crimes committed by youthful addicts.[24] With heroin becoming more scarce and therefore more expensive, younger addicts have tended to become more violent in their efforts to obtain money for heroin. Their older counterparts, on the other hand, have tended to substitute other drugs until heroin is more freely available. It is a near truism in penology that the earlier one becomes involved in crime, the greater the likelihood of continued involvement. Thus, special emphasis must be placed on rehabilitating younger addicts before they become irretrievably caught up in the drug use crime cycle.

Characteristics of Arrestees

This segment of the discussion analyzes various relevant characteristics of addict-arrestees charged on drug law or nondrug law violations. The information is adapted from demographic and criminal history data of arrestees contained in two major studies in selected American cities.[25]

DEMOGRAPHIC CHARACTERISTICS

The overwhelming majority of arrestees found to be heroin users are:[26]

(1) male—85 percent,
(2) young—70 percent under 30 years of age,
(3) black—62 percent (an additional 16 percent are Spanish-speaking),
(4) urban—83 percent live in large metropolitan areas, and
(5) unemployed—61 percent.

[22] Drug Usage and Arrest Charges, pp. 44–46.
[23] Ibid., pp. 44–46.
[24] "The NARA II Admission: A Description" (U.S. Government Printing Office, Washington, D.C., 1972), pp. 3–5; Drug Usage and Arrest Charges, p. 70.
[25] The cities included in these statistics were analyzed in two separate studies: "Drug Usage and Arrest Charges," and "Selective Justice: Drug Law Enforcement in Six American Cities" (see footnote 4), then combined for this report by the subcommittee staff. The cities are New York, Chicago, Los Angeles, Washington, D.C., Miami, Dallas, St. Louis, New Orleans, and San Antonio.
[26] Drug Usage and Arrest Charges, pp. 70–82; Selective Justice, pp. 508–510.

HISTORY OF DRUG USE

(1) 22 percent of arrestees who had used heroin were addicted at the time of their arrest.
(2) Extensive drug histories were more often found among Spanish-speaking (29 percent) and black (23 percent) than among white arrestees.
(3) 70 percent of arrestees had received no prior treatment for drug dependency.

PRIOR POLICE CONTACT

(1) 63 percent of all those arrested had been arrested previously.
(2) 46 percent had been previously arrested for drug law violations.
(3) 56 percent had prior nondrug arrests.
(4) 38 percent had been arrested three or more times for nondrug offenses.
(5) Those who were arrested a second time were more likely to be involved in nondrug felony crimes. Also, the incidence of violent crimes increased with each arrest.

PRIOR CONVICTIONS

(1) 35 percent of those arrested for violating narcotic laws had been convicted of a prior felony or misdemeanor.
(2) 23 percent had at least one prior drug law conviction.

PRIOR INCARCERATIONS

Arrestees who had previously been convicted were likely to have been incarcerated as well:

(1) 28 percent of arrestees had been incarcerated for nondrug offenses.
(2) 18 percent had been incarcerated for drug offenses.

As indicated by the foregoing statistics, the criminal justice system presently is little more than a revolving door for a large number of addict-arrestees. Many have been arrested, re-arrested and convicted previously and nearly 30 percent have spent time behind bars. Yet, they seemingly have not been deterred from returning to heroin and further criminal activity.

The failure of the criminal justice system to disrupt the drug use-criminal activity cycle by the traditional means of arrest, prosecution, and incarceration is perhaps best understood in terms of the behavioral patterns which develop as a result of repeated criminal conduct and the impact heroin has on the development of these patterns. Penologists have long recognized that as an individual's criminal history lengthens, it generally becomes more difficult to rehabilitate him. A type of criminal lifestype emerges to which he finds it increasingly easier to return after each release from legal detention. In most instances, heroin addiction greatly accelerates the emergence of this criminal lifestyle. First, as mentioned earlier, the high price of heroin usually forces the addict into thievery or selling heroin to others in order to maintain his habit. Second, even if the addict is blessed with abundant financial

resources, he is a criminal by the mere fact that possessing heroin is against the law. And, finally, heroin is such a physically addicting drug that it is difficult for an addict to develop enough willpower to kick the habit and go straight without some rather dramatic changes in his circumstances. Seemingly, even after he has developed the will to quit heroin, the body continues to crave it physically.

Disposition of Drug Cases

Once an addict is arrested, his chances of going to trial, or to jail, on a felony or misdemeanor charge, are fairly remote. One exhaustive study into the disposition of drug law violations found that 58 percent of the cases were disposed of at some point between arrest and trial—usually by outright dismissal.[27] Only 30 percent of all individuals arrested on drug law violations were convicted and sentenced; and among those sentenced, about half were sentenced to incarceration. The rest received suspended sentences or were placed on probation.[28] The result was that only 14 percent of those arrested for drug law violations actually served time in jail.[29]

These findings are closely paralleled by the drug arrest statistics for New York City and Washington, D.C. In 1968, of the 12,800 arrests for possession of narcotics in New York City, almost 65 percent were either dismissed or acquitted at trial.[30] The dismissal rate for "drug loitering" cases has been around 90 percent. A review of the incarceration figures in New York City for drug misdemeanor violations during 1969 and 1970 reveals that 20 percent of the arrests resulted in incarceration.[31] In Washington, D.C., a recent study concluded that only 16 percent of those arrested for drug law violations and drug-related crimes were incarcerated.[32] At the Federal level, during fiscal year 1972, there were approximately 12,500 arrests for Federal drug law violations.[33] Of those arrested, about 5,900 were convicted and 3,400 sentenced to imprisonment. Thus, approximately 27 percent of the persons arrested at the Federal level spent time in prison.

The conclusion from available arrest and incarceration data is that narcotics addicts, once apprehended, spend little or no time in jail, and are soon back on the streets doing what they were doing before they were arrested. There is little chance of their being convicted. If convicted, they have little chance of receiving either an extended jail sentence or any type of treatment for their addiction. This means that law enforcement agencies are arresting more and more heroin addicts each year, but, as in the past, doing little to break the drug use-criminal activity cycle.

The experiences of the 1930's, 1940's, and 1950's convinced most drug abuse experts that harsh legal sanctions and long prison terms alone

[27] Selective Justice, pp. 556–563.
[28] Ibid., pp. 563–572.
[29] Ibid., pp. 572–576.
[30] "Narcotic Drug Control in New York State," a report by the Legislative Commission on Expenditure Review (Albany, N.Y.), 1971, pp. 81–82.
[31] Ibid.
[32] "Staff Report, American Bar Association Special Committee on Crime Prevention and Control: The Case for Pretrial Diversion of Heroin Addicts from the Criminal Justice System" (Washington, D.C.), 1972, p. 11; hereinafter cited as "The Case for Pretrial Diversion."
[33] "Report of the Proceedings of the Judicial Conference of the United States" (U.S. Government Printing Office, Washington, D.C. 1972), pp. 382, 386, 388, 389, and 391.

cannot eliminate the ultimate causes and consequences of heroin addiction. During those years, many addicts were sent to prison where, because of the absence of heroin, they were forced to kick the habit. Moreover, they remained heroin-free during the often lengthy duration of their imprisonment, only to find themselves again taking heroin after being released. The relapse rate during that period is considered to have been above 90 percent.[34]

Unfortunately for the criminal justice system, the current judicial leniency toward narcotic law violators has proved no more effective in reducing drug-related crime or in rehabilitating addicts than was the "lock 'em up and throw away the key" approach of the previous four decades. Heroin addiction and the attendant problems of drug-related crime were not solved by punishing addicts, but they have not been solved by withholding society's sanctions, either. In fact, studies by the General Accounting Office and others show that releasing addicts and sellers back into their communities with no imprisonment or treatment only exacerbates the heroin problem in those communities.[35] In all but a few instances they simply resume their activities, usually within hours of leaving the precinct station.

Heroin addiction is an acute physical illness and, given our growing repugnance for capital punishment or similar draconian methods used in some Middle Eastern countries with, reportedly, rather dramatic results, the only effective corrective appears to be quite intensive and extensive treatment. This fact has caused a small but growing number of jurisdictions to begin substituting some form of heroin treatment for unconditional pretrial release or normal imprisonment. The subcommittee found that where this has occurred, both heroin use and drug-related crime have been reduced significantly.

Diversion of Criminal Addicts

The criminal justice system basically has two alternatives for dealing with drug addicts once they have been arrested. They can either be processed through regular criminal channels without regard to their drug dependency, or they can be diverted into community-based drug treatment programs. At present, the vast majority of addicts are processed through regular criminal channels. However, as mentioned above, conventional deterrence-oriented law enforcement is unable to produce a substantial reduction in drug use or drug-related crime. Further, there are the growing expenses of arresting and prosecuting addicts, and the delays caused by overburdened court dockets and seriously overcrowded prisons. Hence the Federal Government and some State and local jurisdictions have begun diverting addicts into treatment as an alternative method of dealing with those who enter the criminal justice system. This section of the report discusses the mechanics of pre- and post-trial diversion, and analyzes the results of some diversion programs currently in operation.

[34] *Licit and Illicit Drugs*, p. 78.
[35] Report of the Comptroller General to the Congress, "Limited Use of Federal Programs To Commit Narcotic Addicts for Treatment and Rehabilitation" (U.S. Government Printing Office, Washington, D.C.: 1971), hereinafter cited as "Limited Use of Federal Programs To Commit Narcotic Addicts."

It should be noted at the outset that diversion does not necessarily mean escape from the penal sanctions of incarceration. As the New York State Commission of Investigation, Narcotic Law Enforcement in New York City, put it: [36]

> Although it is generally believed that treatment for the addict-defendant is an approach which allows individuals to avoid incarceration, it is clear that in major metropolitan areas like New York, available statistics support the opposite conclusion, namely, that treatment alternatives for such addict-defendants are not in lieu of incarceration, but rather in lieu of non-incarceration.

This statement can best be understood in light of the statistics presented in the previous sections of this report—for example, about 65 percent of misdemeanor arrests for possession in New York City are dismissed or acquitted, and over one-third of all felony narcotic cases are dismissed.[37]

Diversion can be used as a sentencing alternative before or after a formal trial takes place. Generally speaking, pretrial diversion involves removing an arrestee from the regular criminal process after arrest but before trial, and referring him to a community-based treatment center as a condition of release. Posttrial diversion, on the other hand, involves placing an addict in a treatment program that is administered by the criminal justice system itself—either a highly supervised out-of-prison treatment center or a special drug program established within the prison.

The term "diversion" was first applied to the criminal justice system in 1967, when President Johnson's Commission on Law Enforcement and the Administration of Justice recommended "the early identification and diversion to other community resources of those offenders in need of treatment, for whom full criminal disposition does not appear required." [38] It had become apparent to the members of the Commission that in many cases, criminal disposition was ineffective in deterring or rehabilitating heroin addicts. Informal diversion involving a broad range of criminal offenses has been going on for years in many cities through the exercise of discretion by local prosecutors in proceeding with charges in a particular case. In return for the defendant's agreeing to enter a treatment program or psychiatric counseling, the prosecutor would agree to dismiss or not to prosecute. This form of ad hoc diversion has not proved effective. Like plea bargaining, it is dependent upon a subjective, often nonprofessional, evaluation of the defendant and upon the persuasiveness of the defendant's lawyer to make a deal for his client. Many addicts who need treatment simply don't receive it under informal programs.

PRETRIAL DIVERSION

In contrast to informal diversion, pretrial diversion as a formal systematic mode of case disposition generally provides for an adjournment of court proceedings after arraignment but before trial on condition that the defendant enroll in a community-based drug treatment program. No plea or conviction is entered on the defendant's record at that time, and after a specified period of case adjournment, the court will dismiss the charges or order a resumption of the prosecution, depending on whether the defendant's progress in treatment has been satisfactory. As with informal diversion, pretrial diversion programs rely on the exercise of prosecutorial discretion (too much, according to many critics). However, pretrial diversion has the distinct advantage of providing the criminal justice system with a parallel mechanism for processing criminal addicts, a system familiar to the police, prosecutors, defense lawyers, the courts and finally the addict himself. Since it is formalized, its successes and failures can be charted and compared with orthodox methods of processing criminals.

From a theoretical standpoint, there are two great advantages of pretrial diversion over traditional criminal processing: First, it takes groups of persons who are least responsive to criminal sanctions, such as addicts, out of the criminal justice system at the earliest possible stage. They are channeled early into social service and treatment programs which are better designed to solve the underlying medical and psychological problems of the addict. Second, it provides for early referral to outpatient treatment, which helps conserve prosecutorial and judicial manpower, greatly reduces the congestion of court calendars, and frees sorely needed space in jails and prisons for more serious criminals. The heavy burdens on our criminal justice system are well known. The phenomenal increase in drug abuse over the past decade has contributed greatly to the strains felt by this system at all levels. Some police departments have had to create narcotic units to fill a need that had not existed before, and it was not uncommon for local jurisdictions to experience a 100-percent increase in drug arrests during a single year.

Statistics on the services performed by the San Francisco Police Department Crime Laboratory in 1960 and 1970 are indicative of how severe the impact of drugs on our criminal justice system has been. The total number of narcotic cases handled by the laboratory rose from approximately 400 in 1960 to more than 3,900 in 1970. Although the staff was increased from two criminologists to four, in 1971 an estimated 38 percent of staff time was devoted to the analysis of marihuana alone.[39]

The criminal justice system can be seen as a logical vehicle for diverting heroin addicts into treatment. It is well known that addicts are highly resistant to seeking treatment voluntarily. Further, the criminal lifestyle necessitated by addiction sooner or later brings the addict into contact with law enforcement authorities. As a result, pretrial diversion serves as both carrot and stick in bringing addicts into treatment.

At the other end of the system, drug users constitute a major portion of the jail population in the United States. One study found that in 1966, 40 percent of the jail population in New York City admitted a

[36] "Arrest Histories Before and After Admission to a Methadone Maintenance Program," Addiction Services Agency (New York), 1973, p. 4.
[37] Ibid., p. 2.
[38] "President's Commission on Law Enforcement and Administration of Justice, Task Force Report: Narcotics and Drug Abuse" (U.S. Government Printing Office, Washington, D.C., 1967), p. 32.
[39] "San Francisco Commission on Crime, Report of Non-victim Crime in San Francisco, Part III: Dangerous Drugs and Narcotics" (San Francisco), 1971, p. 18.

history of drug use.[40] A later study reported that 44 percent of the inmates in the District of Columbia jail were dependent on heroin.[41]

As a defendant proceeds through the criminal justice system, the number of public employees required to process the case becomes legion. In addition to police personnel, there are the prosecuting attorney, a public defender in many cases, the court clerk, the judge, bailiffs, a court reporter, perhaps a panel of jurors, and other supportive personnel. Clearly, the decision to prosecute any case is a costly one.

As mentioned in an earlier section of the report, about half of the drug violations are never prosecuted, and only about 14 percent of all individuals arrested for drug law violations ever serve time in prison. In all likelihood, part of the reason for the failure to prosecute many cases lies with the legitimate problems of large prosecutorial caseloads, and the long waits between arrest and trial. Furthermore, the fact that most persons convicted of possession of narcotics are not being imprisoned suggests the court's awareness of severe overcrowding in prisons and the limited resources available to prison administrators to rehabilitate drug addicts.

THE DISTRICT OF COLUMBIA—A CASE STUDY IN PRETRIAL DIVERSION

The subcommittee staff examined in considerable detail the diversion program administered by the District of Columbia criminal justice system. They talked with program personnel, observed arrestees being processed through the courts into treatment programs, visited four Narcotics Treatment Administration neighborhood facilities, and studied data that have been compiled on the D.C. program. Much of the analysis on pretrial diversion that follows is based on this investigation.

The District of Columbia has invested considerable resources in developing programs to rehabilitate criminal addicts. The courts utilize sophisticated urine testing and arrestee interviewing programs that provide for release on a pretrial bond conditioned upon enrollment into narcotic treatment. Provision for outpatient treatment also is considered at sentencing, particularly when the defendant is scheduled to be placed on probation. The District of Columbia Bail Agency is actively involved in providing information to the courts concerning defendants. This information allows the court to set reasonable bond conditions that are compatible with treatment programs. The courts have at their disposal the Narcotics Treatment Administration—one of the most up-to-date and best financed city treatment programs in the Nation. There are no waiting lists, and each court referral can choose between methadone maintenance, methadone detoxification, and drug-free therapy. Treatment centers are located in most neighborhoods with medical and social services available to the addict. Beyond the municipal services available to the courts, there are several privately operated drug treatment programs that accept court referrals. Notwithstanding the District of Columbia's impressive commitment of resources for its diversion program, its experience indicates that diversion is not a trouble-free alternative to incarceration.

[40] New Perspectives on Urban Crime, pp. 31–32.
[41] The Case for Pretrial Diversion, p. 65.

Two major conclusions can be drawn from a survey of the program data for the District of Columbia: (1) To be fully effective, diversion programs must adequately supervise and monitor an addict's performance once he has been referred to treatment; and (2) where an addict does remain in treatment for the length of time specified as a condition for his release, he is less likely to be involved in subsequent criminal activity than those defendants who are not referred to treatment or who drop out before completion.

A study of the case histories of 1,716 arrestees released into treatment before trial revealed that:[42]

(1) About 25 percent of the referrals never enrolled in treatment of any kind;

(2) Another 25 percent dropped out of treatment before the end of the first month;

(3) About 62 percent either never entered treatment or dropped out before the time specified by the court as a condition of release; and

(4) Eighty-five percent failed to remain in treatment for 6 months or more.

The failure of 62 percent of the arrestees to remain in treatment seemingly argues against any expansion of this program.

However, one of the important findings of the same study was that addicts who did remain in treatment, even for short periods of time, were less likely to be rearrested than those who had dropped out. For example:[43]

(1) Sixty-five percent of all arrestees who had received no treatment were again arrested; 44 percent of those who had received less than 6 months treatment were subsequently arrested; and 39 percent of those receiving more than 6 months of treatment were arrested again.

(2) The rearrest rate for those who remained in treatment more than 6 months was 40 percent less than for those who had received no treatment at all.

The strong contrast between the dismal retention rates, and the encouraging impact on recidivism of treatment when the arrestee remained in the program, indicates that the failures in the District of Columbia program were due to inadequate supervision, not ineffective treatment. The failure of 62 percent of the addicts to adhere to the conditions of their release shows that they had little fear of the potential legal sanctions that could have been used against them, and that while pretrial diversion is founded on the court's coercive power to order treatment for the arrestee, little coercion actually is applied when the arrestee fails to comply with the court's order. Only 22 percent of the violations of treatment conditions were reported to the courts, and the courts took action on a small percentage of these.

DETROIT—A STUDY OF POSTTRIAL DIVERSION

In Detroit, the recorder's court administers a postconviction drug diversion program. Judge Robert L. Evans, Director of the LEAA-funded program, testified before the subcommittee that the key to his

[42] Ibid., p. 53.
[43] Ibid., pp. 69–71.

program's success has been the close supervision of the probationer's activities by parole officers and the threat that the probationer will be sent to prison if he does not adhere to the conditions of his release. Says Judge Evans:

> We know then that if they are assigned to a therapeutic community (and only about 10 percent of them are) that they are going to do whatever the therapeutic community requires; that is to say, live in the house and do whatever is required. If they are assigned, as at least 50 percent of them are, to a methadone maintenance center, they are going every day and getting their methadone and getting whatever services that the methadone maintenance center offers. But they have, with our program, the additional input from the probation officer who acts as an enforcer. He is the guy, whether he expresses it verbally or not, who says: If you don't measure up, I will tell the judge on you and will send you to prison. This is the mechanism that makes our program work.[44]

In the first program year, the Recorder's Court referred about 1,500 parolees to treatment and it monitored (through urine samples) the progress of 1,000 more. Judge Evans reported to the subcommittee that 75 percent of those under treatment were not arrested during the first year.

There are advantages and disadvantages to both posttrial (such as the Detroit program) and pretrial diversion. Most of the prosecutors and law enforcement officials interviewed by the subcommittee staff expressed a strong preference for posttrial diversion. They have found that an addict is much more likely to adhere to the conditions of treatment with the threat of a prison sentence hanging over his head. To be sure, the Washington, D.C., experience shows that where the defendant does not respect the potential sanctions that can be used against him, or where those sanctions are never used, the program has considerably less chance of success. Treatment personnel, on the other hand, generally prefer diversion immediately following arraignment because it gets the addict into treatment much sooner, gets more addicts into treatment, and reduces the number of drug-related cases on court calendars.

At the beginning of this report, it was stated that our primary concern is with reducing the high cost of administering the Nation's criminal justice system. Under ideal conditions, pretrial diversion would do this best. However, unless a pretrial program includes a strong supervisory and monitoring component, similar to that discussed by Judge Evans, it becomes a vehicle for beating the system, not improving it. For all practical purposes, the 62 percent in Washington, D.C., who dropped out of treatment were simply released back into the community to continue abusing drugs and committing crimes.

Supervision and monitoring procedures are most critical during the first 6 months of treatment. According to a General Accounting Office study, it is within this period that a majority of addicts drop out of treatment.[45] Thus, a pretrial program must develop a monitoring system that can detect potential failures quickly and provide counseling and supportive services while there is still a possibility of keeping these persons active in treatment. In addition, court supervision should continue from the point of pretrial release through sentencing itself.

[44] Hearings (pt. 3), p. 676.
[45] Limited Use of Federal Programs To Commit Narcotic Addicts, p. 11.

This type of close monitoring and supervision would not only provide stricter guidance over defendants released into treatment, but also make it possible for the individual agencies of the criminal justice system to know what is happening at each stage of the defendant's progress through the pretrial program.

CIVIL COMMITMENT

Civil Commitment was the first systematic alternative to incarceration for narcotic addicts. Beginning in 1961, after the Supreme Court in *Robinson* v. *California* had suggested that compulsory treatment of addicts under "medical" confinement was a constitutional alternative to imposing "criminal" sanctions, several States and the Federal Government enacted laws authorizing the courts to divert addicts found guilty of committing crimes while under the influence of heroin to State hospitals or hospital wards within prisons for extended periods of treatment.[46]

CIVIL COMMITMENT UNDER NARA I AND III

The Narcotic Addict Rehabilitation Act of 1966 (NARA) signaled an important shift in Federal policy toward heroin addicts.[47] As a National Institute of Mental Health report on NARA indicated: "The Act represents the view that narcotic addiction is symptomatic of an illness that should be treated and not a criminal circumstance in itself." [48] Titles I and III of NARA direct the U.S. Department of Health, Education, and Welfare to provide in-patient care and community aftercare for certain classes of narcotic addicts. The most important difference between the two titles is that Title I provides for commitment in lieu of prosecution, while Title III provides for the voluntary commitment of an individual not charged with any crime.

Title I provides that if a Federal District Judge believes that a defendant is a narcotic addict, he may advise the accused that the prosecution of the charge will be held in abeyance if he submits to an examination to determine whether he is an addict and likely to be rehabilitated through treatment. It is solely within the discretion of the judge whether he will offer the defendant treatment under Title I. The act does not require the court to do so.

The judge also is required to inform the defendant that, once committed, he may not voluntarily withdraw from treatment; that the in-patient phase of treatment may last up to 36 months; and that, at the discretion of the Surgeon General, he may be conditionally released to supervised aftercare in the community. If the defendant successfully completes treatment, the criminal charge pending against him will be

[46] 370 U.S. 660 (1962).
[47] Title I: 28 U.S.C. 2901–06 (1970); Title II: 18 U.S.C. 4251–55 (1970); Title III: 42 U.S.C. 3401 et seq. (1970).
[48] National Institute of Mental Health Report on the Narcotic Addict Rehabilitation Act of 1966, (U.S. Government Printing Office, Washington, D.C.: 1966) p. 2.

dismissed. However, if he fails to complete treatment successfully, prosecution of the charges against him will be resumed.

The treatment procedures of examination, in-patient care and after-care that an addict receives under Title III of NARA resemble those just described under Title I, except that Title III patients have not been charged with any crime. The most significant difference between the care received under the two titles is the time period involved: a Title III patient receives only 6 months of in-patient care.

Viewed from several key perspectives, civil commitment under Federal and State laws has proved unsatisfactory in rehabilitating large numbers of heroin addicts. First of all, civil commitment has suffered from gross underuse. When NARA was first enacted, the Department of Health, Education, and Welfare estimated that 900 individuals would be committed each year for treatment under Title I.[49] In practice, however, the General Accounting Office found that only 179 addicts had been committed under Title I during the first three years of the program's operation.[50] Title III has been similarly underused. The GAO reported that approximately 57 percent of those voluntarily applying for treatment during the first three years were rejected as being "unsuitable for treatment." [51]

According to the GAO, one of the principal reasons for the limited use of Title I centers around its strict eligibility requirements. The following classes of defendants are not eligible to be committed under Title I or NARA:

> 1. An individual charged with a crime of violence;
> 2. An individual charged with unlawfully importing, selling, or conspiring to import or sell a narcotic drug;
> 3. An individual against whom there is pending a prior charge of a felony which has not been fully determined or who is on probation or whose sentence following conviction on such a charge, including any time on parole or mandatory release, has not been fully served: *Provided*, That an individual on probation, parole, or mandatory release shall be included if the authority authorized to require his return to custody consents to his commitment;
> 4. An individual who has been convicted of a felony on two or more occasions; and
> 5. An individual who has been civilly committed under [the NARA] Act, under the District of Columbia Code, or any State proceeding because of narcotic addiction on three or more occasions."

In short, hard-core addicts and felons who need treatment the most do not qualify for it under Title I.

Second, civil commitment proved to be more expensive than incarceration. Dr. Vincent Dole, a metabolism specialist at Rockefeller University, with broad experience in the area of heroin addiction, testified before the House Judiciary Committee that at the peak of

[49] Ibid., p. 2.
[50] Limited Use of Federal Programs To Commit Narcotic Addicts, pp. 11–14.
[51] Ibid, p. 2.

its utilization, the New York City program was spending $30 million per year to treat only 5 percent of the city's addicts.[52]

And finally, the rehabilitative accomplishments of the programs have been disappointingly small. A recent three-year follow-up study of 1209 California addicts released after their first commitment indicated that 71 percent returned to using illegal drugs; 63 percent returned to opiates.[53] From the same sample, 67 percent were recommitted one or more times under the civil commitment statute. The study further showed that 33 percent had received a new criminal conviction.[54]

POSTTRIAL DIVERSION

The Bureau of Prisons—NARA II and DAP

The Federal Bureau of Prisons is charged with administering treatment programs for addicts committed under Title II of NARA. Prior to 1968, most addicts convicted of Federal crimes were sent to prison, where they served time without receiving any treatment for heroin addiction. Upon release, the typical addict-prisoner returned to his previous lifestyle of addition, with its attendant complement of crime. His stay in prison, irrespective of length, served no rehabilitative function; often he was rearrested within a short period after his release.

During the past six years, this situation has improved markedly with the establishment of eleven drug treatment programs in ten Federal prisons. Five of the programs are for offenders committed for treatment under Title II of NARA; the other six are part of the recent Drug Abuse Program (DAP) designed to provide treatement for the addicts not committed under NARA II. Now just under 1,500 Federal inmates participate in in-prison treatment programs—approximately 7 percent of the total Federal prison population—and the Bureau foresees extending the program to include about 2,000 inmates in all Federal prisons.[55]

Under Title II of NARA, an addict who has been convicted of a Federal crime can be committed to treatment in one of the five NARA prison units. Not all addicts are eligible for treatment under Title II. The Act specifically excludes the same classes of defendants as those excluded under Title I. The majority of the Federal courts have construed these eligibility requirements rigidly. As in the case with civil commitment, the result is that those who need treatment the most are excluded.

[52] "Committing Narcotic Addicts Under the Narcotic Addict Rehabilitation Act of 1966," hearings before a subcommittee of the Committee on the Judiciary, House of Representatives (U.S. Government Printing Office, Washington, D.C., 1970), p. 324.
[53] "Institutional Patterns Among Civilly Committed Addicts," Journal of the American Medical Association, vol. 208, No. 12, June 23, 1969, pp. 2297–2301; "One Year Follow-Up of All Residents Released From the California Rehabilitation Center" (Sacramento) (1971), p. iii.
[54] "Institutional Patterns Among Civilly Committed Addicts," ibid., p. 2299. Title III of the Narcotic Addict Rehabilitation Act is now used in conjunction with the criminal justice system as a vehicle for funding community-based treatment programs such as Second Genesis, in Alexandria, Va. In many instances, admission to such programs is part of a posttrial disposition, wherein the judge places the defendant on probation for an extended period with the condition that he enroll in such a program. The defendant then petitions the appropriate U.S. District Court for civil commitment under NARA III and, upon acceptance into the program, NARA III money is used to pay for the treatment received at the community-based treatment center.
[55] Hearings (pt. 3), pp. 735, 737.

To fill this gap, the Bureau of Prisons instituted the DAP program, which accepts any inmate who has a drug problem. There are no eligibility requirements relative to prior criminal records or drug use for DAP.

To illustrate how sentencing under NARA II works, if a Federal court believes that an offender is an addict and determines that he is eligible for NARA II treatment, it may place him in the custody of the U.S. Attorney General for examination to determine whether he is in fact a narcotic addict. If it is determined that he is one, he may be committed to treatment under NARA II. He will be placed in a NARA II unit for a period of time which cannot exceed the maximum sentence that would have been imposed for the crime he committed; nor can it any case exceed ten years.

In practice, most addicts committed under NARA II remain in the institutional phase of treatment for from one year to 18 months. During this phase, the inmate participates in extensive group therapy—the core of the Bureau of Prisons treatment program. When the prisons' NARA staff feels that an inmate is ready for conditional release to community aftercare, they make the appropriate recommendation to the Parole Board. Once he has been released conditionally, the offender is legally on parole. During this time, he receives counseling and vocational assistance from a community agency under contract with the Bureau of Prisons.

In order to treat Federal inmates who are not eligible for NARA II treatment, the Bureau has established six DAP units. Structurally, the program closely resembles NARA II. Participants live in segregated units where they receive intensive psychological counselling—primarily group therapy.

The chief feature distinguishing DAP from NARA II is that the former is open to users of all drugs and to inmates irrespective of former criminal records. Furthermore, participation is strictly voluntary, and withdrawal from the DAP unit does not affect the sentence originally imposed by the court.

The most difficult task facing the Bureau's drug treatment staff is that of preparing the inmate for the transition from prison to the outside world. This transition is particularly traumatic for the NARA II or DAP inmate because of the stark contrast between the Spartan atmosphere of the prison therapeutic community and the permissive attitudes of most urban communities.

It is still too early to evaluate the Bureau's success in rehabilitating addicts under the NARA II and DAP programs. The aftercare component of these programs has been in operation for less than three years, and only about 300 NARA II and DAP inmates have completed inpatient treatment and been paroled into the aftercare phase of the treatment package.

However, case studies of those parolees now in aftercare are encouraging, and the program does show considerable promise of reducing the problem of recidivism among former addicts. For example, none of the parolees who have been released into aftercare have been returned for violating the conditions of their parole. This does not mean that there has been no drug use among NARA II or DAP parolees. There has been some, but the incidence has been minor. In recent years,

the Bureau of Prisons has adopted a more realistic level of expectation regarding the conduct of former addicts.

The Bureau views "success" in its overall treatment program as parole without violation—i.e., no criminal activity and no drug use. To help prevent the relapse of paroled inmates, the Bureau assigns them to aftercare treatment under supervision of a parole officer. In the past, any parolee found using drugs was subject to immediate revocation of his parole. Today, the Bureau of Prisons recognizes that heroin addiction is a long-term illness requiring a long-term cure, and that evidence of minor drug relapse is not proof that the former addict has been a treatment failure.

Treatment Modalities

DRUG-FREE PROGRAMS

Basically, drug-free programs view drug dependence as a result of personality deficiency and an inability to cope with one's environment. In most instances they utilize some form of behavior modification in a setting that divorces the individual from his normal surroundings. The goal is to restructure the addict's personality and help him cope with the everyday stresses in his life.

The most widely used methodology of drug-free treatment is the therapeutic community. A therapeutic community has been aptly described as a setting where:

> The addict spends months, even years, in a milieu designed to restructure his psyche from immature and addiction prone into strong, self-reliant, and no longer in need of a drug "crutch." Simultaneously, the therapeutic community milieu provides the ex-addict with a drug free social setting in which all the mind pressures are directed toward abstinence rather than relapse.[56]

The Phoenix Houses, administered by the Addiction Services Agency of the City of New York, constitute the country's largest community-based therapeutic program. Since most therapeutic communities follow similar organizational and functional patterns, a brief description of Phoenix House provides a general reference of how therapeutic communities operate.

Addicts come into the program through neighborhood storefront units manned by former addicts, and through recruiting efforts at correctional institutions. Candidates for Phoenix House programs usually spend from one to three months in the neighborhood unit while they break their drug habit. Detoxification is available for those who need it at a local hospital. The policy of Phoenix House is to admit anyone "who has abused drugs," but approximately 80 percent of the persons admitted are heroin addicts.

The only criterion for admission to the Phoenix House is a "desire and commitment to change, to grow up, and to solve the emotional and social problems that generally underlie the drug problem." Phoenix House has developed three general approaches to achieve these goals.

[56] Rosenthal, Mitchell S. and D. Vincent Blase, "Phoenix Houses: Therapeutic Communities for Drug Addicts," Hospital and Community Psychology, January, 1969, p. 46.

The first is therapy. Although all activities of the House are designed to have a therapeutic effect on the addict, the heart of most drug-free therapy is the encounter group. An encounter group forces each member to verbalize his personal and interpersonal problems. Each resident participates in several encounter sessions a week. Participants often engage in a verbal "street fight," where yelling, screaming, crying, swearing, and in fact all forms of emotional expression except physical violence, are encouraged. (It should be noted that some other therapeutic communities, particularly those dealing with teenage addicts, stress supportive, rather than "attack" or encounter therapy.)

The encounter sessions are to be both cathartic and educational. The main objective is to strip the addict of his pretenses and facades, force him to look more honestly at himself and his predicament, and teach him how to react and behave in a more socially acceptable manner. The subcommittee staff viewed an encounter group session on videotape at the Petersburg Federal Prison. The verbal abuse unleashed back and forth by members of the group was brutal, and the only defense was complete honesty and a tough psychological skin. The following list describes the encounter groups offered in the Danbury Federal Prison drug rehabilitation program run by a private organization known as "Daytop."

I. *Regular groups*—

Encounter or hostility groups.—Every inmate who has a complaint or negative feeling about another inmate or staff member is supposed to save it for these group meetings. One person at a time becomes the focus of hostility for the others.

Peer groups.—The activities vary but peer groups are always composed of inmates who are at the same "behavior level."

Static groups.—The membership of a static group is constant. Inmates discuss their personal problems.

II. Special groups which meet less regularly—

Data sessions.—They may be used to teach such things as the structure of the NARA house and the chain of command.

Image-breaking seminars.—Inmates act out roles of women and other roles which are contrary to the ones they are perceived as playing.

Educational seminars.—Inmates may have to read in preparation and report on current events.

General meetings.—Meetings of the whole house for discussion on an important matter.

Recreational seminars.

Morning meetings.—To discuss the day's business.

Reentry group and certification groups.—For those inmates soon to be released.

House retreats.—These occasional, intensive, house-wide discussions of a single topic may last for several days.

The second approach is educational and vocational training, which involves developing job skills and a better understanding of the way the "straight" world operates. This is accomplished by (1) assigning residents to a job in one of the House's seven "departments" where he works, can be promoted, demoted, or transferred out, much like an

employee in any outside job, (2) having the addict attend vocational training classes and (3) requiring him to attend a variety of educational seminars aimed at stimulating conceptual thinking and basic intellectual skills.

Although most therapeutic communities provide some form of vocational training and counselling, they do not place heavy emphasis on job-related matters. Job training seems to be viewed more as an end in itself, a useful therapy, and less as a means for helping the addict qualify for a job.

The third approach in the Phoenix House program is referred to as "social-communal rehabilitation." The primary objective of social-communal rehabilitation is to bring greater order to the addict's daily life, and increase his identity with, and involvement in, socially acceptable patterns of behavior. This is achieved by pairing new residents with former addicts who serve as positive "role models" and by exerting strong pressures on the resident to conform to well-defined codes of behavior. House rules are strictly enforced and all infractions are penalized "justly but severely"—usually through some form of social ostracism.

As mentioned earlier, the therapeutic community attempts to instill within the addict the belief that his addiction is a result of his immaturity, irresponsibility, and emotional instability. In fact, most therapeutic communities believe that until the addict recognizes these shortcomings in his personality, cure is impossible.

METHADONE DETOXIFICATION AND MAINTENANCE

Doctors involved in narcotics research and treatment may disagree about particular facts on addiction, but they seem to be in agreement on one basic point—heroin addiction is a physical illness. It has long been known that drugs, whether heroin or alcohol, can produce physical dependence. The classic prescription for an unhealthy dependency is abstinence. Drug-free programs today supplement this with the concept of restructuring the individual's coping mechanism so that abstinence can become permanent. However, not all experts agree that personality deficiencies are the prime cause of addiction. Some argue that addiction creates a physiological craving which many cannot resist unless it is satisfied or negated, at least for some time. Accordingly, a number of substitutes for heroin have been the subject of experimentation, especially in the last few years. Some of these try to block the craving for heroin. Others negate its effects. At present, the most widely used chemical is methadone. Methadone hydrochloride, a synthetic narcotic developed by the Germans during World War II, was first used in the treatment of heroin addiction in the mid-1950's.

Many patients receiving methadone do so only for a limited period; the purpose is to ease the physical discomforts of withdrawal from heroin. The process, which can last up to 21 days, is termed detoxification. The first step consists in transferring the addict from heroin to methadone. The daily dose is then progressively reduced over a ten-day to three-week period until the level reaches zero. During the detoxification period, the addict is counseled when he comes in for his methadone.

Methadone maintenance was pioneered by Drs. Vincent P. Dole and Marie E. Nyswander in 1964. They had placed their patients on methadone as a step toward withdrawal, but instead of reducing the methadone immediately, they kept the patients on high doses for a considerable length of time in order to compare the metabolic effects of morphine and methadone. Today, ten years later, more addicts are being treated in methadone maintenance clinics than in all other modes of treatment combined. Most major cities have methadone programs, including large-scale programs in New York and Washington, D.C., and the number of addicts presently under treatment totals about 100,000.

Since the Dole-Nyswander experiments have provided the model for most methadone maintenance programs that have followed, a brief description of the original Dole-Nyswander program will help illustrate how methadone programs operate. As initially designed, the program was divided into three phases: [57]

Phase one

Addict patients were stabilized with methadone in an unlocked hospital ward, given a complete medical check-up, psychiatric evaluation, a review of family and housing problems, and a job-placement study. After the first week of hospitalization, they were free to leave the ward for school, libraries, shopping and various amusements—usually, but not always, with one of the staff. Patients lacking a high school diploma were started in classes to prepare them for a high school equivalency certificate. This initial stage was arbitrarily set by Dole-Nyswander at six weeks.

On admission most patients usually showed some signs of withdrawal which were relieved by a shot of morphine. The patients were then started on a 10 to 20 mg. dose of methadone twice daily. At the start of the program the dose was gradually increased for a four-week period to the individual's stabilization level.

During this phase of hospitalization, the treatment unit was kept small (4–9 patients). This was determined to be necessary since some patients started the treatment with serious psychological problems, anxieties, and doubts. The limit on patient load allowed the staff to individualize the daily ward activities and to deal with the special problems of each patient.

Phase two

This began when the subjects left the hospital and became outpatients, returning every day for methadone medication. They were asked to drink their medication in the presence of a clinic nurse, and to leave a daily urine specimen for analysis. When indicated, this rule was relaxed: Reliable patients who had been in the program several months were given enough medication for a weekend at home or a short trip. Continued contact with the hospital staff was provided as required. The most important nonclinical service needed during this phase of treatment was help in obtaining jobs, housing and education.

[57] Vincent P. Dole and Marie Nyswander, "Heroin Addiction—A Metabolic Disease," in Archives of Internal Medicine, vol. 120, No. 1, July 1967, p. 27.

Phase three

This phase was the goal of the treatment program, the stage in which an ex-addict became a socially normal self-supporting person. The only distinction between patients in phase two and three was in the degree of social advancement. Officials of the Beth Israel Hospital in New York, one of the agencies administering the New York City methadone maintenance program, were visited by subcommittee members during a trip to that city. They told of patients who had been using methadone for a number of years and continued to do so while holding down responsible, high-paying jobs in industry.

The degree of success of the Dole-Nyswander experiment was remarkably high. As the use of methadone spread, however, programs sprang up which resembled the pilot project only in dispensing methadone. Patients were given methadone without adequate supervision and subsequently it turned up on the black market. Physicians took advantage of their power to prescribe methadone to enrich themselves, with the result that methadone became widely available on the streets. The situation reached the point that the Director of the Bureau of Narcotics and Dangerous Drugs stated that methadone was the number two drug problem in the country.

This misuse of methadone by clinics, doctors, and patients required action by Governmental regulatory agencies. A drug with the potential of staying or overcoming heroin addiction was itself becoming dangerous; deaths from methadone overdoses were reported in increasing numbers. The Government moved to get greater control over the handling and dispensing of methadone.

In 1973 the Food and Drug Administration adopted comprehensive regulations outlining procedures to be followed by methadone maintenance programs.[58] Generally the regulations require a program to:

(1) "provide as a minimum, counseling, rehabilitative and other social services (e.g., vocational and educational guidance, employment placement), which will help the patient become a well-functioning member of society." Moreover, "evidence will be required to demonstrate that the services are fully available and are being utilized."

(2) be affiliated with a hospital,

(3) be approved by the FDA and the State authority,

(4) determine that an applicant has been addicted at least two years prior to admission to maintenance treatment,

(5) not admit to treatment in a maintenance program persons under the age of 16, and admit patients between 16 and 18 only under limited conditions. The conditions are that persons between 16 and 18 will be admitted to maintenance only with parental approval, and only where there is a documented history of two or more unsuccessful attempts at detoxification and a documented history of dependence on heroin or other morphine-like drugs beginning two years or more prior to application for treatment.

(6) provide minimum staffing and ensure access to a comprehensive range of medical and rehabilitative services to its patients,

[58] 21 CFR 130 : Federal Register, Dec. 15, 1972.

(7) establish procedures that ensure minimal diversion of methadone, in accordance with regulations promulgated by DEA. The regulations are very specific concerning limitations on take-home privileges for methadone.

(8) Generally limit methadone maintenance treatment to a period of two years.

Methadone as medicine

Methadone maintenance was developed as a mode of treating heroin addiction on the theory that the regular use of opiates has a chronic effect on the central nervous system. The theory is that following regular exposure to opiates, the central nervous system adjusts to their presence, and when they are withdrawn the nervous system gets out of balance. One medical specialist has analogized this phenomenon to our normal dependence on vitamins "which the body cannot manufacture for itself. . . . If a normal man's vitamins are cut off he becomes sick." [59]

The Addiction Research Center in Lexington, Kentucky, conducted a study on the long-term physiological effects of opiate addiction. The Center reported:

> We have shown that following withdrawal of patients dependent on morphine and methadone, there is a long-lasting syndrome of physiological abnormalities which has been called protracted abstinence, which appears to be characterized by hyperresponsivity to stressful stimuli and which is associated with relapse to the drug of dependence.[60]

These "physiological abnormalities" which are hyperresponsive to "stressful stimuli" are perhaps best illustrated by what one veteran drug program administrator told the subcommittee staff. As an addict he had been committed to the Public Health Service Hospital in Lexington for two years and upon leaving the hospital he was fully convinced that after two years of drug-free life he had successfully kicked the habit and would never return to drugs. However, during the train ride to his home in Washington, D.C., he began experiencing acute withdrawal symptoms. He broke out into a cold sweat, felt nauseous and was afflicted with cramps and diarrhea; the closer he got to home the worse the symptoms became. He reached Washington that night and by morning he had his first fix of heroin.

If heroin addiction is a long-term physical illness, whose effects can reappear months even years after withdrawal apparently has been achieved, the question must be asked: What lasting impact will placing an addict in the drug-free environment of a prison cell have on his addiction? First of all, proponents of the therapeutic community approach generally would answer "virtually none," because incarceration without intensive therapy fails to remedy the psychological and social deficiencies that caused and will perpetuate his addiction. Second, for different reasons, many doctors involved with the problem would agree—"virtually none," since the physical changes

[59] Licit and Illicit Drugs, p. 161.

[60] Martin, William R., "Commentary on the Second National Conference on Methadone Treatment," International Journal of the Addictions, vol. V. No. 3, Sept. 1970, p. 548.

in the addict's body that do not respond to abstinence alone have not been treated.

Moreover, in many instances those who hold a biomedical view of addiction would answer "virtually none" if asked a similar question: What lasting impact will placing an addict in the drug-free environment of a therapeutic community have on his addiction? One methadone maintenance program administrator interviewed by the subcommittee staff readily admitted that psychological and social factors can increase or decrease the likelihood of readdiction. Nonetheless, his criticism of drug-free therapy was similar to that mentioned above—the physical changes in the addict's body that do not respond to abstinence alone have not been treated.

It would be inaccurate to suggest that there is a general consensus in the medical profession as to what causes heroin addiction and how it should be treated. Most doctors agree that addiction is a physical illness, but after that, there are numerous shades of opinion regarding the changes in the body produced by extensive use of heroin.

It is beyond the expertise of this Committee to venture a judgment on which the theories or sub-theories of heroin addiction are valid. Scientists, physicians, psychologists, and social workers have debated the question for years without reaching a generally acceptable conclusion. Nonetheless, whether heroin addiction results in irreversible metabolic changes or physical dependence which is part of a larger psychological dependence, it is important to recognize that basically methadone is used to treat addiction as if it were an internal disorder much as insulin is used to treat diabetes.

Many proponents of methadone often compare this maintenance to therapies used in medical practice for the treatment of patients with chronic metabolic disorders—insulin for diabetes, digitalis for cardiac malfunctions, or cortisone for arthritis. Patients with these chronic diseases depend on their medication to function normally. According to proponents, the methadone patient, who is also dependent on his daily dose of medication, is in the same medical status.

The term "methadone maintenance" is somewhat misleading. It implies that an addict will be maintained on high doses of methadone indefinitely. To be sure, some will. For example, one program administrator told the subcommittee staff that he had a 70-year-old client who took 170 mg. of methadone daily—two or three times the average dose—and worked 16 hours a day at two jobs. When the center, without the knowledge of the client, tried to reduce this dosage by a slight amount, the client became ill. As the administrator pointed out, this particular addict, and some like him, may require maintenance at high dose levels for long periods of time, if not indefinitely.

However, it should be kept in mind that most methadone programs either maintain their patients on very low dosages or slowly reduce the dose levels until the addict is fully withdrawn from methadone after periods varying from several months to two or three years. As previously mentioned, recently adopted FDA regulations limit methadone maintenance treatment to two years plus extensions which can only be obtained upon approval by FDA.[61]

[61] See note 58, supra.

Probably the main reason methadone programs prefer to maintain patients at low dose levels or withdraw them from methadone altogether is that methadone, like heroin, is a dangerous and highly addictive drug. Those who become dependent on methadone are "addicted" both physiologically and psychologically. Suddenly removing their doses of methadone would precipitate severe withdrawal symptoms similar, if not identical, to those experienced in heroin withdrawal. Thus, substituting methadone for heroin simply means substituting one addiction for another.

If methadone is similar to heroin, why not supply addicts with legal doses of heroin, as is done in Great Britain? Although the effects of the drugs are somewhat similar, substituting methadone for heroin does have several important advantages. First, methadone is fully effective when taken orally. This eliminates the dangers of spreading infectious diseases through unsterile hypodermic needles. Second, methadone is a relatively long acting drug. A dose is effective for approximately 24 hours, compared to four or five hours for heroin. Researchers are working on even longer acting methadone that would be effective up to 72 hours. This fact enables an addict to function rather normally throughout the day, without the anxieties produced by a nearly constant craving for heroin. Since the addict on methadone does not need to pattern his daily routine around the obtaining and consuming of heroin, he can hold down a job or attend school. And third, methadone staves off the unpleasant effects of heroin withdrawal and the post-addiction syndrome of anxiety, depression and heroin craving, without producing the euphoric stupor of heroin.

An Evaluation of Treatment Modalities

In evaluating the relative effectiveness of drug-free therapy and methadone maintenance, it is important to keep in mind that because they differ so vastly in their basic philosophies, it is difficult in some instances to draw valid comparisons. This is particularly true in evaluating their success in keeping addicts abstinent from heroin. Obviously, any criterion used to measure the drug-free status of methadone patients must be defined in relative rather than absolute terms, since methadone maintenance initially is directed toward the substitution of methadone for heroin and not primarily toward withdrawal from all drugs.

1. A first standard for evaluating the success of treatment is the percentage of addicts who remain in treatment after they have enrolled. Drug-free programs have long been plagued with notoriously high drop-out rates. Brecher writes that "without a single known exception [therapeutic communities] represent a major disaster, for they have helped persuade the public that heroin addiction is curable without curing more than a trivial number of addicts." [62] He took a sample of 157 residents of Phoenix House in 1968, and found that two years later:

(1) 40 were still affiliated with the program, of whom 17 were employees, 12 were in treatment, 10 were program "elders," and one was the wife of the program director.

[62] Licit and Illicit Drugs, p. 80.

(2) 117 had left the program, 100 of them having dropped out without graduating.

Another study made of residents in Phoenix House found that 71 percent of the 385 residents chosen at random had left the community "against clinical advice" and more than 60 percent had dropped out within the first year.[63]

Methadone maintenance programs, on the other hand, generally have enjoyed high retention rates. For example, during the subcommittee's hearings in New York City in 1973, Dr. Robert Newman, Director of the city's methadone maintenance programs, testified that roughly 80 percent to 85 percent of the addicts who enter New York City's methadone program are still actively enrolled in treatment one year later.[64] In the District of Columbia's pretrial diversion program, the average methadone maintenance patient remains in treatment about three times longer than the average patient in drug-free programs. This difference is accentuated by the fact that a large majority of addicts prefer methadone maintenance over drug-free treatment. For example, four times as many participants in the District of Columbia's pretrial diversion program choose methadone maintenance over drug-free treatment.

2. A second standard for judging success is abstinence from heroin. Abstinence in drug-free therapy must be analyzed from the perspective of in-residence and post-residence abstinence. Several studies show that heroin use is greatly reduced during the time an addict resides in a therapeutic community, but that the number who relapse to heroin use upon graduating or dropping out is staggering. This is probably best understood in terms of socialization. From the moment an addict enters a therapeutic community, enormous peer pressures are exerted on him to conform to the community's code of behavior. Once the pressures and supports of the therapeutic community are removed, many addicts revert to using heroin. Charles Dederich, the founder of Synanon, has stated:

> I know damn well if they go out of Synanon they are dead. A few, but very few, have gone out and made it. * * * We have had 10,000 to 12,000 persons go through Synanon. Only a small handful who left became ex-drug addicts. Roughly one in ten has stayed clean outside for as much as two years." [65]

A followup study of several hundred addicts treated in hospitals revealed a relapse rate of roughly 95 percent.

The in-residence success of therapeutic communities in deterring drug use must be qualified by the following two factors:

(1) Therapeutic communities are rather selective in admitting into their programs. Generally speaking, only the more highly motivated addicts who demonstrate the willingness to endure the discipline and rigorous routine demanded of residents in the community are accepted. Applied to an unselected cross-section of addicts, rather than only to the more personally motivated, the therapeutic community approach

[63] De Leon, George, Sherry Holland and Mitchell S. Rosenthal, "Phoenix House: Criminal Activity of Drop Outs," Journal of the American Medical Association, vol. 222, No. 6, Nov. 6, 1972, pp. 685–689.
[64] Hearings (pt. 4), p. 1084.
[65] Licit and Illicit Drugs, p. 78.

is much less successful in keeping addicts actively enrolled in a therapeutic community at any given time.

As previously mentioned, because of philosophic differences regarding the goals of treatment, it is somewhat misleading to draw comparisons between abstention from heroin in drug-free programs and in methadone maintenance. However, it is clear that more addicts who enter methadone maintenance stay off heroin for longer periods of time than those who enter therapeutic communities. Testimony received by the subcommittee and program evaluations reported in several professional journals indicate that approximately 80 percent of those who have enrolled in methadone maintenance programs over the past decade can be considered heroin-free.[66]

(2) Whether or not the greater success of methadone maintenance in getting heroin addicts off heroin and keeping them off can be explained in terms of metabolic changes or medication for a physical disease, undoubtedly it is much easier to "succeed" in methadone maintenance than it is in drug-free therapy. Many patients who enter methadone programs purposely seek to avoid the intensive psychological counseling and military-style discipline characteristic of drug-free therapy. In short, it is much easier to "kick the habit" with the help of methadone than it is to survive the hardships of total abstinence and the rigors of the therapeutic community.

This is not intended as a criticism of methadone maintenance. As a basic proposition, any treatment that makes it easier for an addict to get off and stay off heroin should be encouraged. It should be kept in mind that for nearly a century heroin addiction in this country had not responded to available forms of treatment. Until recently, that treatment did not utilize psychological techniques such as group therapy, however.

Of course, it is only natural that most people would prefer an addict to be fully withdrawn from all narcotic drugs—including methadone. They are unconvinced that the methadone patient's status is analogous to that of the diabetic. To them, methadone is just another form of addiction. They are correct in that methadone is addictive and clients need their daily supply—at least until programmed dosage reductions reduce their dependence. But programs try to decrease the amount of the drug being ingested; whereas addicts self-administering heroin generally use increasing amounts. And the goal of methadone programs is stabilization of the individual so that he can function as nonaddicted people do—although an addictive drug is the initial means to achieve this.

Even though alleviating a specific dependence by substituting a more benign one raises troubling questions, the fact remains that methadone maintenance has been much more successful than drug-free therapy in restoring addicts to useful lives in the open community. Referring to the experiences at Synanon, Charles Dederich has stated:

> We once had the idea of graduates. This was a sop to social workers and professionals who wanted me to say that we were producing graduates. I always wanted to say to them, "a person with this fatal disease will have to live here all his life." [67]

[66] Hearings (pt. 4), p. 1088.
[67] Licit and Illicit Drugs, p. 78.

Synanon and some other therapeutic communities no longer consider themselves as treatment centers but rather as an alternative way of life where an addict and his family can remain indefinitely. The majority of therapeutic communities, however, still embrace the goal of returning the addict to society. Through job counseling, and in some instances sheltered workshops, they attempt to prepare the addict for entry into the economic mainstream of the outside world.

Whether the approach to prepare for life in a new environment or for re-entry into the old one, is reclusion or re-entry, it seems clear that only the more highly motivated should be diverted into drug-free treatment. Those responsible for administering diversion programs should interview the defendant thoroughly, and if they have question regarding his ability to adapt to the rigors of drug-free therapy, methadone maintenance should be recommended. A large majority of addicts request methadone programs and, as stated earlier, more addicts remain in methadone programs than do in drug-free treatment.

3. A third, and for the purposes of this report the most salient, criterion for evaluating the success of drug treatment is the effect treatment has on the addict's subsequent criminal behavior. DeLeon, Holland and Rosenthal have found that irrespective of the high drop-out rate in therapeutic communities, drug-free therapy—even on an abbreviated basis—has a positive impact on criminal conduct. By and large, drop-outs commit fewer crimes than addicts who never entered treatment.[68]

SUCCESSES IN DRUG-FREE PROGRAMS

In the DeLeon, Holland, and Rosenthal study, some three hundred eighty-five residents of Phoenix House were chosen at random. From this sample, 71 percent had left the House "against clinical advice," and more than 60 percent within the first year of residency. The study reported:

	Percent
(1) Arrest rate for drop-out group:	
(*a*) Prior to entering the program	49.2
(*b*) During the program	2.8
(2) Arrest rate for group remaining:	
(*a*) Prior to entering the program	45.2
(*b*) During the program	4.8

The important question, of course, is how well did the sample group perform once they had left the therapeutic community? As might be expected, the longer an addict remained in treatment the greater was the reduction in his post-program criminal activity. Even for those addicts who failed to complete the program, arrests continued to remain low in comparison to their before-program levels. Those who stayed in Phoenix House less than three months experienced a 6.7 percent reduction in arrests during the ensuing year; for those who stayed from 3 to 11 months, there was a 40 percent to 50 percent reduction in arrests; and for those who remained for more than twelve months, arrests were reduced by 70 percent of the before-program level.

Of particular interest is the fact that the largest decrements in arrests occurred among involuntary residents. This finding is sup-

[68] Phoenix House: Criminal Activity of Drop Outs, pp. 685–689.

ported by similar studies, and suggests that the therapeutic community can serve as an effective alternative to incarcerating heroin addicts. In terms of diverting addicts to therapeutic communities, criminal justice agencies should be sensitive to two critical periods: (1) The first six months of treatment. (The majority of those who drop out of therapeutic communities do so within the first six months.) (2) The period immediately following release from the therapeutic community, when the ex-addict must cope with his environment without the benefits of structured reinforcement formerly provided by the drug-free treatment program. Thus, a diversion program should be particularly alert to progress within the first six months and should offer intensive followup services for addicts who have completed their residency and are returning to the general community.

SUCCESSES IN METHADONE PROGRAMS

The potential of methadone in rehabilitating criminal addicts became evident early in its use as a treatment for heroin addiction. In 1964, New York City established a trial program at the Rockefeller University Hospital that four years later showed a 94 percent success rate in ending the criminal activity of patients. Prior to treatment, 91 percent of the patients had been in jail, and the crimes committed had resulted in over 4500 convictions. After entering the treatment program, 88 percent of the patients showed arrest-free records, and of those who were arrested, about one half had their cases dismissed.

Methadone maintenance has continued to be successful in reducing the arrest rates of enrollees. For example, an analysis of arrest histories of applicants to New York City's methadone maintenance program showed the following: [69]

1. *All Admissions—First half-year in Treatment.*—During the first six-month period after admission, there was a 57 percent decrease in arrest rates compared to the rate one year prior to admission. Also, whereas 40 percent were arrested one or more times during the year prior to entering treatment, only 11 percent were arrested in the 6 months following admission.

2. *Patients in Program 7 months or more—Arrest Histories 1–6 and 7–12 months after Admission.*—These subjects also showed a significant decrease in arrest rates (63 percent) during the first half-year in treatment, and then a leveling off the second six months.

The percent of patients arrested during the year before admission was 38 percent, while only 10 percent were arrested during the first six months in treatment. There was a further drop to 8 percent during the second half year in the program.

3. *Patients in Program 13 months or more—arrest histories 1–6, 7–12 and 13–18 months after admission.*—The average stay in treatment for this group of patients was 14.4 months.

The arrest rate prior to admission for these patients was somewhat higher than for those in treatment a shorter period of time.

[69] "Arrest Histories Before and After Admission to a Methadone Maintenance Treatment Program," pp. 3–6.

The arrest rate following admission, however, was even lower than for the other groups, and the change from the pre-admission rate was even more dramatic: 84 percent decrease during the first half year, 76 percent the second half year, and a rate 13–18 months after admission which was 90 percent lower than before entering the program.

The percent of patients with one or more arrests also dropped markedly following admission: 43 percent arrested at least once during the year prior to admission, against 7 percent during the first 6 months in treatment, 9 percent during the second six months, and only 4 percent arrested during treatment months 13–18.

4. *Cumulative arrest rates following admission according to length of time in treatment.*—The total post-admission arrest rate and the pre-admission rate for each group of patients shows a striking decline in post admission arrest rates in all groups: 57 percent for all patients after an average of 5.2 months in treatment; 61 percent after an average of 10.1 months; and a decline of 82 percent after an average patient stay of 14.4 months in the program.

The subcommittee's investigation into the District of Columbia methadone program, and information it received from several program administrators across the country, suggest that the success rates cited above are higher than those in most other methadone programs. Nevertheless, the decrease in arrest rates for individuals in methadone treatment is impressive.

Of course, the larger goal of social rehabilitation involves more than stopping addicts from using heroin and stealing to buy it. Methadone may remove the physical craving for heroin, but, it does not attack the emotional, social, and economic problems that cause individuals initially to turn to drugs. In addition to stabilizing his physical condition, an addict needs guidance by personnel trained to deal with his emotional difficulties, lack of occupational and educational skills, and family and community problems. It is on this point that methadone maintenance has been most severely criticized. Too many methadone programs still do not provide the supportive services needed to produce long-range changes in the addict's life style. They have been derisively termed "filling stations," because an addict can stop by for a quick fill up on methadone, and then take off without the "hassle" of supervision and counseling.

An inescapable conclusion of the subcommittee's investigation is that effective drug treatment is both long term and expensive. Estimates of cost vary. A research psychiatrist for one treatment program claims that it costs his State approximately $1,300 a year to rehabilitate one addict. Doctors in another program estimate that six weeks of inpatient treatment followed by aftercare treatment totals $3,000. And finally, the Misdemeanor Branch of the District of Columbia Superior Court received $150,000 from the Law Enforcement Assistance Administration (LEAA) to initiate a limited pre-trial program. This program is designed to accommodate about 30 defendants, which would put per-patient cost in the neighborhood of $5,000.

These costs, however, must be viewed against a background of the current costs to process and, because of the high incidence of repeated criminal violation by heroin addicts, to reprocess addicts through the criminal justice system without intervening treatment. It was brought out in the Introduction of this report that the District of Columbia alone spends $17 million annually to arrest, prosecute, and imprison heroin addicts. Thus, the costs of providing addicts with high-quality treatment are comparative and not absolute. Rehabilitating heroin addicts and restoring them to useful, productive lives in their communities could save a sizable portion of tax resources allocated each year to controlling drug-related crime.

The Federal Strategy on Drug Abuse states that it is the goal of the Federal Government to make treatment available to every heroin addict in the United States. The yearly cost for such treatment could exceed current Federal spending on all phases of drug abuse control. But it would be a bargain if it helps to reduce the price society pays for this disease in crime, stolen property and law enforcement expenses attributable to heroin addiction.

○

END